DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAID PURCHASING ADMINISTRATION
Olympia, Washington

To: Resource Based Relative Value Scale (RBRVS) Users:
- Anesthesiologists
- Advanced Registered Nurse Practitioners (ARNPs)
- Blood Banks
- Emergency Physicians
- Family Planning Clinics
- Federally Qualified Health Centers
- Health Departments
- Laboratories
- Managed Care Organizations
- Nurse Anesthetists
- Ophthalmologists
- Physicians
- Physician Clinics
- Podiatrists
- Psychiatrists
- Radiologists
- Registered Nurse First Assistants

Memo #: 10-45
Issued: June 28, 2010

For information contact:
1-800-562-3022, option 2, or go to:
http://hrsa.dshs.wa.gov/contact/default.aspx

Supersedes Memo #: 09-40

From: Douglas Porter, Assistant Secretary
Medicaid Purchasing Administration (MPA)

Subject: Physician-Related Services: Fee Schedule and Policy Updates

Effective for dates of service on and after July 1, 2010, the Department of Social and Health Services (the Department) will implement:

- The updated Medicare Physician Fee Schedule Database (MPFSDB) Year 2010 Relative Value Units (RVUs);
- The updated Year 2010 Relative Value Guide base anesthesia units (BAUs);
- The updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- The updated Medicare Average Sales Price (ASP) drug files;
- Consultation services policy (99241-99245 and 99251-99357);
- Changes to vision care services; and
- The technical changes listed in this numbered memo.

Overview

All policies previously published remain the same unless specifically identified as changed in this memo.

Fee Schedule Updates and Maximum Allowable Fee Adjustments

Effective for dates of service on and after July 1, 2010, the Department will update the *Physician-Related Services Fee Schedule* with the Year 2010 RVUs, BAUs, clinical laboratory fees, and Medicare ASP pricing. The Department will adjust the maximum allowable fees to reflect these updates.

Bill the Department your usual and customary charge.

Viewing Changes to the Fee Schedule

To view these changes go to the Department/MPA website online at: http://hrsa.dshs.wa.gov/RBRVS/Index.html.

Conversion Factors

Below are MPA's July l, 2010, conversion factors:

Title	Procedure Codes	July 1, 2010 Conversion Factor
Adult Primary Health Care	99201-99205, 99211-99215	21.96
Anesthesia		21.20
Children's Primary Health Care	99201-99215, 99381-99395, 99460-99463	36.22
Clinical Lab Multiplication Factor		00.76
Maternity	59000, 59025, 59400-59410, 59425-59426, 59430, 59510-59525, and 59610-58622	43.50
All other Procedure Code (except Clinical Laboratory)		22.23

Coverage Changes

The Department has changed the following procedure codes from covered to noncovered.

Procedure Code	Brief Description
90657	Flu vaccine, 6-35 mo, im

The Department has changed the following procedure code from non-covered to covered

Procedure Code	Brief Description	Comment
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use.	Free from DOH for ages 2 months to 71 months.

The Department has changed the following procedure codes from noncovered to covered with expedited prior authorization (EPA).

Procedure Code	Brief Description	Prior Authorization
G0290	Drug-eluting stents, single	EPA
G0291	Drug-eluting stents, each add	EPA

The Department has changed the following procedure codes from covered with prior authorization (PA) or EPA to covered without PA or EPA:

Procedure Code	Brief Description	Prior Authorization
31825	Repair of Windpipe Defect	N/A
31830	Revise Windpipe Scar	N/A
92980	Insert intracoronary stent	N/A
92981	Insert intracoronary stent	N/A

The Department has changed the following procedure code from covered without PA to covered with PA.

Procedure Code	Brief Description	Prior Authorization
G0251	Linear acc based stero radio	PA

Consultation Services (99241-99245 and 99251-99255)

Effective January 1, 2010, Medicare decided to not cover CPT codes 99241-99245 and 99251-99255 and directed healthcare providers to use CPT codes 99201-99205, 99211-99215, 99221-99223, or 99304-99306. The Department will apply Medicare's policy to Medicare/Medicaid dual-eligible clients. However, for Medicaid-only clients, the Department will still cover CPT codes 99241-99245 and 99251-99255. Please see table below:

For Medicare/Medicaid Dual-Eligible Clients	For Medicaid-Only Clients
99201-99205, 99211-99215, 99221-99223, or 99304-99306	99241-99245 and 99251-99255

Changes in Vision Services

Add New EPA Number

Effective for dates of service on and after July 1, 2010, the Department will cover Miraflex frames for children when all of the following clinical criteria are met:

- The client is less than 5 years of age; and
- The provider has documented the reason(s) that the standard Airway Optical frame is not suitable for the child.

In order to receive payment, providers must follow the Department's expedited prior authorization (EPA) process. See the Department/MPA *Vision Care Billing Instructions*, EPA #611 **Expedited Prior Authorization Criteria Coding List** on page D.4.

Update to EPA for Lost or Broken Eyeglasses for Adults (EPA #615)

Effective for dates of service on and after July 1, 2010, the Department will cover the replacement of a complete pair of eyeglasses (frame and lenses) for adults (21 and older) **once** in a 24-month period. If the client requires eyeglasses due to loss or breakage, before the 24-month period has expired, the Department will require prior authorization. This limit applies to clients age 21 and older. It does not apply to clients (of any age) of the Division of Developmental Disabilities (DDD), or to children.

All other policy information with regard to EPA #615 remains unchanged."

Unclaimed Eyeglasses

If a client does not return to the provider's office to pick up eyeglasses, then the provider should do the following:

- Keep the completed pair of eyeglasses for three months; and
- Make a good faith effort (a minimum of three attempts) to contact the client.

After the above are met, the provider may keep the glasses to use for repair parts

> **Note:** An adult client is not eligible for glasses for 24 months from the date of last dispensing, unless prior authorization is obtained. This does not apply to clients of the Division of Developmental Disabilities, or to children.

Changes to the Billing Instructions

Below are changes the Department made to the *Physician-Related Services Billing Instructions*:

Change	Page
Changed second bullet on page to read: "Preventive medicine services (except EPSDT exams for clients 20 years of age and younger and those clients with developmental disabilities);"	A.3
Added the July 1, 2010, conversion factors.	A.6
Changed the first sentence in the 2nd round bullet to read: "One pre-operative E&M procedure by a physician for a dental client **prior to performing dental surgery**." Also removed the 2nd paragraph in that bullet.	B.1
Removed the 3rd bullet in the first bulleted list which said: "Not experimental."	C.1
Removed procedure code 90657 from the table and added procedure code 90670 to the table.	C.13
Under the heading: "Respiratory Syncytial Virus (RSV)/Synagis Season" removed the day and year from the date span in the 1st paragraph. Also removed any indication of a particular day or year being tied to this season throughout the billing instructions.	C.17
Added: "or three injections" to 2nd bullet under table.	C.26
Replaced all of the information in this section with the following: Please refer to the current Department/MPA Vision Care Billing Instructions at: http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/Vision_Care.html.	Section D
Added the following note: "**Note:** Please note that this benefit is for children who do not meet the RSN's access to care standards. If it is medically necessary, therapists need to transition care of the child to the RSN, as appropriate to the child's condition."	E.5

Change	Page
Revised the 1st bullet underneath the table to read: "Providers may bill a combination of panels and individual tests not included in the panel. Duplicate tests will be denied. Providers may not bill for the tests in the panel separately per the National Correct Coding Initiative."	E.32
• On page F.2, inserted a note that says: "**Note:** Refer to Section K of these billing instructions for information on when it is necessary to bill the Department for a chemotherapy drug using an unlisted drug code. • On page F.3, removed section titled: "Unlisted Drugs:" • On page F.4, removed section titled: "Invoice Requirements."	F.2-F.4
• Corrected the alphabetized order of subsections within the EPA Criteria section. • On page I.6, added revised language under EPA code 615 (Dispensing/Fitting Fees for Glasses) • On page I.7, added EPA code and criteria for 611 (Miraflex Frames). • On page I.9, removed procedure codes 92980 and 92981 from "Placement of Drug Eluting Stent and Device."	I.6-I.11
Added a section titled: "What Drugs Are Covered?" This is from WAC 388-530-2000(1).	K.9
• On page K.12, added some NDC requirements and reorganized the page. • On page K.13, pasted the "Invoice Requirement" section that was cut from page F.4.	K.12-K.13

How Can I Get the Department/MPA Provider Documents?

To download and print the Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).